SUPPORTIVE HOUSING INITIATIVE

TRAINING MANUAL FOR PROJECT EVALUATORS

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Chapter 1
Introduction

Background

Funding for the Supportive Housing Initiative Act (SHIA) was established in the FY 1999-2000 budget at $1 million per year for three years. In FY 2000-01, the funding grew to $26.1 million. In FY 2001-02 the funding was adjusted to $21.1 million. The California Department of Mental health (DMH) is currently funding 46 SHIA projects. Additional information is provided on the DMH website at http://www.dmh.cahwnet.gov/pgre/suphsingpage.htm.

SHIA grant money can be used to provide an array of supportive services to clients in housing for up to 3 years as well as housing rental subsidies for up to 15 years. SHIA projects are required to participate in an outcomes evaluation as directed by DMH.

Overview of Evaluation

In order to qualify for supportive housing grant funding, each organization agreed to participate in the DMH project evaluation process as designed by DMH to meet the legislative requirements of Sections 53305 and 53311 of the Health and Safety Code.

SECTION 53305. (a) The lead agency shall ensure that adequate resources are available to conduct an evaluation. The lead agency shall ensure that an evaluation of this chapter is conducted and completed as follows:

(1) An interim evaluation shall be completed and submitted to the Legislature at the end of the first 18 months in which grants are first awarded.

(2) A final evaluation shall be completed and submitted to the Legislature within nine months of the end of the three-year grant period.

(b) The evaluation shall be based upon the outcomes and methodologies for measuring success in achieving each proposed outcome identified by grantees, and shall, at a minimum, include outcomes related to cost avoidance, housing stability, quality of services, and the health status of tenants.

(c) The lead agency or its designee shall provide technical assistance to local jurisdictions in designing and completing the evaluation, including identification of a methodology for collecting the necessary information, and assistance with obtaining that information from state agencies to the extent necessary.

(d) The lead agency or its designee shall compile the information on outcomes from all grantees into a single interim evaluation, and a single final evaluation.

SECTION 53311. The lead agency shall annually prepare and provide a report to the Legislature no later than July 1 of each year that describes all of the following:

(a) The number of persons housed pursuant to the program.

(b) The extent of housing stability.

(c) The demographic characteristics of those housed pursuant to the program, including veterans, people with mental illness, people with substance abuse histories, single adults, and families with children.

(d) The counties and cities in which the housing is located.

(e) The changes in income levels of those housed.

(f) Improvements in health status, to the extent available.

Overview of Training Manual

The following chapters will provide the details about the evaluation and the data collection forms. Chapter 2 will provide an overview of the evaluation design. Chapter 3 will explain the procedures to inform the clients about the evaluation and gain consent to participate. Chapters 4 through 6 review the data collection instruments. Chapter 7 summarizes the responsibilities of the Project Evaluator. The appendices contain a list of project codes and a review of psychometric concepts.

Chapter 2
Evaluation Design

Goals Of Evaluation

The goal of the evaluation is to measure the effectiveness of the SHIA Projects in decreasing the social costs of homeless individuals (e.g., decrease use of emergency medical services, incarceration, and substance abuse), increasing housing stability, providing services to targeted populations, improving mental and physical health, and improving the overall quality of life for service recipients. Additionally, each of the SHIA grantees will be responsible for conducting a cost avoidance analysis for its own project, as well as measuring the success in achieving each of the proposed outcomes identified by grantees in their respective applications.

Evaluation Design

The evaluation is non-experimental. Clients will be administered assessment instruments at admission, every six months, and at discharge. Data collected at admission will provide the baseline for assessing program effectiveness. These data will be collected by project staff.

There are two assessment instruments, plus a Face Sheet, and a Consent to Participate form. These are described briefly on Table 2.1 and in detail in chapters 3 through 6. All forms are in the public domain and there is no charge for using them.

TABLE 2.1 Brief Description of Required Housing Evaluation Forms

FORM	MEASURES	COMPLETED BY
California Quality of Life (CA-QOL)	Family/social contact; adequacy of finances; victimization; arrests; general health status; satisfaction with general life situation etc.	Client
Mental Health Statistics Improvement Program Consumer Survey (MHSIP)	Satisfaction and perceived usefulness of program services; appropriateness of services; and outcomes of care	Client
Face Sheet	Demographic background data, client living situation; project services provided to client	Project Staff
Consent to Participate	Informs clients of study goals, procedures, risks & benefits, and asks for participation	Client & Project Staff

Different assessment periods use different combinations of forms. As Table 2.2 indicates:

- At admission, the Consent-to-Participate form, the Face Sheet and the CA-QOL will be collected.
- At six-month intervals, e.g., six months after admission, 12 months after admission, etc., the Face Sheet, the CA-QOL and the MHSIP Consumer Survey will be completed.
- At the time of discharge, the Face Sheet, the CA-QOL and the MHSIP Consumer Survey will be completed.
- For existing clients already housed at the beginning of the grant funding period, the Face Sheet and the Consent-to-Participate form need to be completed for all clients that would be eligible for the services being funded by the grant monies. As a client avails themselves of the funded services, the client should receive the admission assessment and then receive evaluation forms every six months and if they discharge.

TABLE 2.2 Administration of Housing Evaluation Forms

EXISTING (*ELIGIBLE FOR SERVICES FUNDED*)	ADMISSION or EXISTING (*NOW RECEIVING SERVICES*)	EVERY SIX MONTHS	DISCHARGE
Consent-to-Participate	Consent-to-Participate		
Face Sheet	Face Sheet	Face Sheet	Face Sheet
	California Quality of Life (CA-QOL)	California Quality of Life (CA-QOL)	California Quality of Life (CA-QOL)
		Mental Health Statistics Improvement Program Consumer Survey (MHSIP)	Mental Health Statistics Improvement Program Consumer Survey (MHSIP)

The project evaluator will prepare the forms and give them to the project staff to complete. Within **two months** of admission to the project, the Face Sheet, the Consent-to-Participate, and the CA-QOL must be completed. At six months after the admission date, the Face Sheet and both assessment forms will be completed. At 12 months, 18 months, 24 months, etc., these three forms will be completed for clients still in the program. At discharge, these three forms will be administered. The consent form is signed only once, at admission.

Face Sheet data is still required on clients who decline to participate or who are screened out. This is so that the required demographic, stability, and other types of critical information can be gathered and reported accurately by DMH staff in the legislative reports.

If the client declines to participate, he/she indicates this on the Consent-to-Participate form and the staff will complete the demographic and background items on Face Sheet for the client. No other data will be collected on clients who decline to participate or who are screened out. Projects with high non-participation rates will be closely reviewed.

For clients who are screened out of the project (due to cognitive deficits or a mental illness that makes them incapable of completing the forms), staff will mark the appropriate bubble on the Face Sheet and then complete the demographic and background items on the Face Sheet. No other data will be collected on clients who decline to participate.

This process of semi-annual data collection will be repeated as long as the project continues and the client is participating in the program. When a client is discharged from the program, the Face Sheet and the two assessment instruments will be completed. If the client is unavailable for data collection at discharge, the staff will complete just the Face Sheet for the client.

Other Data Elements

Several data elements may be collected from DMH's Client and Service Information (CSI) System. This information will supplement the CA-QOL. This includes data on type of living situation when receiving services, types of productive activities client engages in and the number of days spent in productive activities. Clients not participating in the CSI system will not have these data.

Target Population

The target population for the Supportive Housing Initiative Projects is very low income Californians with special needs, which include mental illness, HIV or AIDS, substance abuse, chronic health conditions, or developmental disabilities, and may include families with children, elders, young adults aging out of the foster care system, CalWORKS participants, individuals exiting from institutional settings, or homeless people. Any client who enters the demonstration project that is eligible to receive grant funded services will be eligible to participate in the evaluation study. There will be no selection of evaluation participants by the evaluation team.

Consent-To-Participate

Client participation in the evaluation is voluntary. At admission, clients will be asked to sign a Consent-to-Participate form that details the goals of the evaluation, the study procedures, potential risks and benefits, the voluntary nature of participation, and steps to protect confidentiality. The consent is revocable; clients have the right to decline to participate at any point in the research. Clients also will be given a copy of the *Project Evaluation Participant's Bill of Rights*.

The decision to decline to participate in the evaluation is certainly influenced by how staff presents the study to the clients. Staff should make it clear that the goal of the research is to evaluate services, not clients, and that the client's input is critical since he/she is the one receiving the services and is the person best able to evaluate the services received.

Data Collection & Reporting

Data collection on each project will be overseen by the designated project evaluator. The project evaluator will make sure that the data are collected on time and the forms are completed correctly. **It will be the project evaluator's responsibility to get the data submitted to DMH on a timely basis**. The data need to be input on the DMH secure internet web entry forms within 2 weeks of being administered to a client (which should be as per the administration schedule of Table 2.2). Data may also be entered directly online using a paperless interview process if a project has the computer resources available. Please note that an initial registration process is required for each individual who will be logging onto the system prior to actually receiving access. Enter into the secure site by selecting "On-Line Data Entry" on the bottom left of the DMH web site at http://www.dmh.cahwnet.gov/RPOD/default.asp. After data for a client are entered, a confirmation page will appear on the screen. This form may be printed out as verification of data entry.

The completed forms, with the exception of the MHSIP Consumer Survey, can be kept in the client's file. The project evaluator will track the completion of each set of forms and the date input to DMH. This tracking system will be necessary should verification of data entry be needed.

The data collection window for admission data is **60 days from the admission date**. This means that the staff has 60 days from date of admission to complete the administration of the forms. The semi-annual data collection is due 6 months **after the admission collection date**. There is a 30-day window in which to collect the semi-annual data. For example, if admission data are collected on April 10th, the six-month data

must be collected between October 10th and November 10th. The next data collection will be at 18 months, which would be 6 months from the date of the last data collection. For example, if the six-month data were collected on November 10th, the 18-month data collection window would be from May 10th to June 10th.

Data Analysis
DMH staff will complete the data analysis and program evaluation component.

Confidentiality
Client confidentiality must be assured as part of the process of collecting consumer satisfaction data. Therefore, it is recommended that when a client is sent or handed a satisfaction survey, a notice of confidentiality of data be included to reassure the client.

To encourage accurate responses, it is crucial that respondents to the *MHSIP Consumer Survey* be assured confidentiality of their responses so they will not have any fear of retribution. **It should never be returned directly to persons who are providing services**. Service providers should only receive aggregate summary data.

Responsibilities of Project Evaluator
The project evaluator is the key to the successful evaluation of the project. The project evaluators are responsible for a wide variety of tasks at the project level, from preparing the forms for staff use, to ensuring timely data collection. These responsibilities are reviewed in Chapter 7.

Obtaining Forms
All the forms are in the public domain so there is no fee to purchase. A master copy of each form will be provided to the project evaluator. The project evaluator will make copies for the project.

DMH Contacts

On-line Data Entry:
Brenda Golladay
(916) 654-3291
bgollada@dmhhq.state.ca.us

Performance Evaluation
Candace Cross-Drew
(916) 653-4582
ccross@dmhhq.state.ca.us

Supportive Housing Team:
Donna Ures
(916) 653-2634
dures@dmhhq.state.ca.us

Supportive Housing Team:
Linda Aaron-Cort
(916) 654-8643
laaronco@dmhhq.state.ca.us

Chapter 3
Consent To Participate

General Information
Clients have the right to be informed of the goals of the study, to have the evaluation procedures explained, to be told about any possible benefits or risks expected from the evaluation, to be allowed to ask questions about the study, and to be allowed the choice to participate or not in the project evaluation. Clients will be informed of these rights when staff gives them a copy of the *Supportive Housing Initiative Evaluation Participant's Bill of Rights* and the *Consent-to-Participate* form. The consent will be the first form to be completed for each new client.

Administration Procedures
The Project Evaluator will give the *Consent-to-Participate* form and the *Supportive Housing Initiative Evaluation Participant's Bill of Rights* to staff with the packet of the forms that are completed at admission. **Within 60 days of admission**, the client will be told about the evaluation and asked to participate in the Supportive Housing Initiative Project Evaluation.

For existing clients, the Project Evaluator will give the *Consent-to-Participate* form and the *Supportive Housing Initiative Evaluation Participant's Bill of Rights* to staff along with the Face Sheet to be completed at the initial funding of this project. All clients who are eligible to receive the funded services should be administered these forms.

Staff will give the client a copy of the *Supportive Housing Evaluation Participant's Bill of Rights*. The client may keep this copy. The staff will **review each item** with the client.

Next, staff will give the client the *Consent-to-Participate* form. Staff will **review each of the items** on the consent form. Staff will explain to the client that s/he has the right to refuse to participate in the study. The client must be told that if s/he refuses to participate in the study, this will not affect his/her ability to receive services from the Supportive Housing Initiative Project.

If a client is reluctant, s/he should be given time to think about this. It may be helpful to use a peer advocate to explain and discuss the project with a reluctant client. In mental health settings, there are often peer advocates who can discuss and review issues on a one-to-one level with project participants. With other populations, a participant in the project may be able to help administer the forms. While clients must not be

coerced, it is desirable that as many as possible participate in the evaluation. The evaluation is their opportunity to provide feedback about their needs and about project effectiveness.

Once it is clear that the client understands the rights, the staff will ask the client if s/he wants to participate. If the client agrees to participate, the client will sign and date the form, and the staff will sign as a witness and date it as well.

Declines to Participate

If a client declines to participate, the staff will write across the bottom of the form, "Declines" and the client will be asked to sign next to the handwritten "Declines." Note that a client who declines does not sign on the client's signature line; to sign on that line gives consent. Staff will sign and date the forms of clients who decline.

Maintaining Consent Forms

Since the Consent-to-Participate contains the client's name, the form will not be forwarded to DMH. The project evaluator will keep all the Consent-To-Participate forms in a single file. This file may be examined from time to time by the DMH state evaluator. When the file is examined, the project evaluator will obscure the names of clients, thus protecting client privacy.

Obtaining Forms

The State DMH will provide a clean copy of the *Supportive Housing Initiative Evaluation Participant's Bill of Rights* and the *Consent to Participate* form. The project evaluator will make clear copies to distribute to staff.

SUPPORTIVE HOUSING INITIATIVE EVALUATION PARTICIPANT'S BILL OF RIGHTS

Any person who is asked to consent to participate as a client in the Supportive Housing Evaluation, or who is asked to consent on behalf of another, has the following rights:

1. To be told what the study is trying to find out.

2. To be told the procedures to be followed in the evaluation and whether any of the procedures are different from those which are carried out in standard practice.

3. To be told about the risks, adverse effects, and discomforts which may be expected.

4. To be told of any benefits the participant may expect from participating.

5. To be told of other choices available and how they may be better or worse than being in the study.

6. To be allowed to ask any questions concerning the study both before consenting to participate and at any time during the course of the study.

7. To be told of any medical treatment available if complications arise.

8. To refuse to participate at all, either before or after the study has begun. This decision will not affect any right to receive standard services.

9. To receive a signed and dated copy of the consent form and the Bill of Rights.

10. To be allowed time to decide to consent or not to consent to participate without any pressure being brought by the investigator or others.

CONSENT TO BE A RESEARCH PARTICIPANT IN _____
PROJECT'S SUPPORTIVE HOUSING EVALUATION STUDY

Goal of Study

The goal of the evaluation is to measure how effective the Supportive Housing Project is at improving your symptoms, functioning, and the overall quality of your life. (Name of county evaluator) and the State Department of Mental Health are conducting this evaluation. You have been asked to take part in this evaluation because you are receiving services from the Supportive Housing Project. The study will last three years.

Study Procedures

If you agree to participate, this is what will happen:

1) The project staff will provide the evaluators with demographic information about you (e.g., gender, ethnicity), background information, and information about services received from the Supportive Housing Project. This information will not include your name but will contain a client I.D. which will identify your information for the evaluation.
2) You will be asked to fill out the California Quality of Life form. This form asks you to rate your satisfaction with several aspects of your life. This form will take approximately 20-30 minutes to complete. This form will be sent to the evaluators. Again, it will not give your name, but will use a client I.D. number.
3) A mental health clinician will assess your mental health symptoms and provide this information to the evaluators. Again, the form will not contain your name but will use your client I.D. number
4) After you have been in the program for six months, you will be asked to fill out a consumer satisfaction form in order to find out if you are satisfied with the services you are receiving in the Supportive Housing Project. Again, the form will not contain your name but will use your client I.D. number. This forms takes approximately 10 minutes to complete. This form will be mailed directly to the State Department of Mental Health evaluator.
5) Every six months that you are in the project, you will be asked to fill out all the forms and project staff will provide background information to the evaluators. Again, the forms will not contain your name but will use a client I.D. number.
6) This same information, with the exception of consumer satisfaction survey, is collected routinely when you receive mental health services. The only difference is that this information will be collected together with the same information from other clients of the supportive housing project in order to evaluate the services that are being provided.

Risks

The primary risk to you from participating in the study might be that someone not on the evaluation team might see confidential information about you. For example someone might see the forms you complete. To protect against this, we are using a client I.D. number instead of your name. Also, the consumer satisfaction form you fill out will be mailed directly to the State Department of Mental Health Evaluator so that any critical comments you make about the services received in the Supportive Housing Project will

not be read by project staff. This information will be put together with information from other clients in the project and shared with project staff in a summary form so that comments cannot be linked to any individual.

You may experience some discomfort (such as anxiety or frustration) when asked personal questions. Staff will assist you if you become upset by such questions.

Potential Benefits

Your participation in the evaluation may benefit you by providing treatment and services in a more efficient and timely manner. The information you provide may benefit you by helping staff understand you better. Your comments may help improve the services provided. Your participation in the evaluation may not benefit your directly, but the information may be helpful in planning and reviewing the types of services provided to others in the future.

Questions

If you have other questions or evaluation related problems, you may contact (name of county evaluator) at (telephone number).

Voluntary Participation

Participation in this evaluation is entirely voluntary. You may refuse to participate or withdraw form the evaluation at any time. If you choose not to participate, your refusal will have no effect on your ability to receive services from the Supportive Housing Project.

Confidentiality

Evaluation information will be kept separate from any other records. You will be assigned a client I.D. number which will be used for all of the study information and will protect your confidentially to the extent provided by law. This Consent-to-Participate form will be kept by county evaluator, (name of county evaluator). It may be reviewed by the state evaluator but no one else will have access to this information.

Consent

Your signature below gives your consent to participate in the Supportive Housing Evaluation study. It also confirms that you have been given a copy of the "Supportive Housing Initiative Evaluation Participants Bill of Rights" that describes your rights as a participant in this study. If you decline to participate, please write "Decline" across the bottom of the page & your initials.

_____ _____

Client's signature Date Print Name

_____ _____

Legal Representative if necessary Staff witness signature Date

Chapter 4
Face Sheet

General Information
The Face Sheet is to be completed by staff for clients that consent, and partially completed (the demographics portion only) for those that do not consent to participate. The Face Sheet will be completed for each client at admission, every six months thereafter, and at discharge. For existing clients, the Face Sheet is to be completed initially on all clients that would be eligible for the services being funded by the grant monies, and administered again as clients utilize the services funded by the grant monies, and then every six months thereafter, and at discharge. Demographic data will only be collected at admission or, for existing clients, at the initial administration. Each time the Face Sheet is completed, it needs to be input into the State DMH secure internet web entry forms within two weeks.

Development
The Face Sheet was developed specifically for the Supportive Housing Initiative Projects. It was designed to get basic information on each client (as per the legislative requirements of Sections 53305 and 53311 of the Health and Safety Code printed on pages 1-2) without creating a heavy workload for project staff.

Form Completion
The Face Sheet will be completed at every data collection point (baseline, intake, semi-annually, and at discharge). If data is not going to be entered directly on the internet, but rather in paper-and-pencil fashion with the data entry taking place later, the forms should be prepared for staff use. Before the Face Sheet is given to the staff to complete, the project evaluator will enter the correct client identification (ID) number, project code, distribution date, and assessment type in the appropriate fields. These items are described below.

Client ID: This is the project case number for the client as reported to CDS/CSI. The client's identification number be written in the boxes under "Client ID Number" and then the appropriate circles should be marked below. It is critical that this number be correct. If the client does not have a CDS/CSI number, staff will use Social Security Number (SSN). Client ID will also be entered on the bottom of **each** page in the row of nine boxes. It is critical that this number be entered correctly on all pages.

Client Ethnicity: The client's ethnicity should be based on client's self-identification. Staff will fill in the appropriate bubble for ethnicity. Like other demographic characteristics, this is only completed on the first Face Sheet, at admission.

Client Age: The client's age should be age at the time of scheduled administration (i.e., distribution date). Staff will enter the age in the boxes and fill in the circles below with the number. This information will be collected only once, at admission.

Client's Gender: Client's gender refers to client's self-identification. Staff will fill in the appropriate bubble for gender. Note that gender is only collected once, at admission. On subsequent data collections, demographic and background information will not be collected when completing the semi-annual and discharge Face Sheets.

Assessment Type: The evaluator will mark the appropriate circle for "Assessment Type." At admission, the evaluator will mark "Admission." At the semi-annual review (every six months after admission), the evaluator will mark "Semi-Annual." When the client is discharged, the evaluator will mark the "Discharge" circle. For Existing clients receiving an initial administration as eligible to receive services, or who are receiving a more complete administration after availing themselves of services, mark the "Existing" circle.

Note that some clients may decline to participate when asked. The evaluator has no way of knowing this in advance. Thus, the item in the shaded box "Refused to participate" will **never** be filled out by the evaluator. Project staff will mark this choice if a client declines, and erase the assessment choice marked by the evaluator. Likewise, a client may be mentally incapable of completing the self-administered forms, but the evaluator has no way of knowing this in advance. Thus, this item will be completed by staff; it will **never** be filled out by the evaluator. Staff will determine if a client is unable to complete the forms on his/her own or with help from a peer advocate. If staff determines that the client is truly mentally incompetent (due to cognitive deficits or mental illness), the client can be screened out of the evaluation project.

Project number: Enter the project number. This number is a research number assigned by the state evaluator. Enter the number in the boxes and then mark the appropriate circles. See appendix A for project codes.

Distribution Date: Next, the evaluator should complete the field "Distribution Date." This date, along with client ID, is used to link the forms

for any given assessment. This date is the date the forms are given to the staff, not the date the forms were completed. This date **must be the same** on all of the forms for a given administration. For example, at admission both forms (Face Sheet and CA-QOL) must have the same distribution date. The evaluator will write the distribution date in the boxes and then fill in the corresponding circles.

Client's Marital Status: Marital status may be a good predictor of outcomes. Staff will choose the description that best describes the client's marital status at the time of admission to the program.

Status of Children: Identify the status of children related to this client. Mark "none" if the client has no children. Mark "Living with Client" if the client has any children living with them at this time. Mark "Not Living with Client" if the client has children, but none of their children are currently living with them.

After these fields are completed, the evaluator will give the Face Sheet, along with the CA-QOL form that must be completed, to the project staff for completion. The Face Sheet will be completed by project staff within 60 days of the client's entering the program. Note that the time frame is not 60 days from the time the staff get the forms to complete; it is 60 days **from client admission**. Staff will be responsible for completing the rest of the Face Sheet. These items are described below.

Assessment type revisited: If a client declines to participate, project staff will erase the choice of "Assessment Type" marked by the project evaluator, and will fill in the bubble for "refused to participate" on shaded section of the Face Sheet. This is one of only two times that project staff will complete Assessment Type. The other time is when clients are mentally incapable of completing the client-completed forms. In these cases, the staff will mark "screened out." For clients who decline or are screened out, the staff will then complete the rest of the demographic items (age, ethnicity and age) and diagnostic items (i.e., primary mental health diagnosis, substance abuse diagnosis, and client's special needs). This information will permit the state DMH to describe the characteristics of those who are excluded from the evaluation to see if they differ significantly from those who participate. No other data will be collected on those who are excluded and no additional forms (e.g., discharge) will be completed.

Immigrant Status: Mark the appropriate circle (yes, no, unknown) as to whether the client is an immigrant to the United States. If yes, also mark the appropriate category for how long the client has been in this country.

Mental Health Diagnoses: If client has no diagnosed mental problems, select the response, "Not applicable - no known mental health problems." For those with a diagnosis, chose the appropriate diagnostic category. This information will be collected only once, at admission.

Substance Abuse Diagnosis: If the client has no diagnosed substance abuse problems, select the response "not application - no substance abuse problem." For those with a diagnosis, chose the appropriate diagnostic category. This information will be collected only once, at admission. The "unknown" category should be used sparingly.

Client's Special Needs: To be eligible for the SHIA projects, clients must be very low income Californians with special needs. The staff will mark the "yes" bubbles for all those conditions that that they know the client has. Naturally, this would include the special needs that qualify the client for the SHIA programs. Additionally, it could include other special needs as well. For example, a SHIA project is targeting homeless mentally ill people and a client is admitted who is a homeless mentally ill woman with AIDS. The staff would mark the "yes" bubble next to mental illness and the "yes" bubble next to homeless and the "yes" bubble next to AIDS. Note that staff only marks those items that s/he knows about, the staff do not have to interview the client to determine how many special needs the client might have. The idea is to identify the main special needs that staff know about. The staff will then mark the "No" bubbles for all those items that are not special needs of the client. This information will be collected only once, at admission.

History of Chronic Physical Health Problems: Select the one response that best describes the client's history of physical health problems. This information will be collected only once, at admission.

History of Homelessness: Select the one response that best describes the client's history of homelessness. You may have to ask the client for this information. This information will be collected only once, at admission.

History of Mental Health Treatment: Select the response that best describes the client's history of mental health treatment. If they have no history, fill in the "Not applicable" bubble. This information will be collected only once, at admission.

History of Substance Abuse Treatment: Select the response that best describes the client's prior experience with substance abuse treatment. If they have no history, fill in the "Not applicable" bubble. This information will be collected only once, at admission.

Criminal History: Staff will choose the option that best describes the client's criminal justice experiences. This information will be collected only at admission.

Employment History: Staff will chose the option that best describes the client's employment history. This information will be collected only at admission. Information on a client's current employment status will be collected elsewhere.

Employment status: Staff will choose the **one** response that most closely describes client's **current** employment status. Current refers to employment status at the time of scheduled administration (i.e., distribution date). Note that a client may logically be described having two or more of the statuses. For example, a client might be employed in the competitive job market and also be actively looking for work, and also is a student. However, these three responses are meant to be **mutually exclusive.** We are interested in the client's employment status or lack of employment. If the client is employed, that option should be chosen first, rather than the option "CLient is not in the job market." It is the evaluator's job to make sure that staff select only one of the three responses. This information will be completed by staff every time a Face Sheet is filled out.

Client Income: Staff will choose all applicable responses that apply to describe the client's sources of income. This information will be completed by staff every time a Face Sheet is filled out.

Change in Client Income: This item will be completed semi-annually and at discharge. The section is **not** completed at admission. Staff will choose the **one** response that describes the change in client income since the last administration of the instrument (typically 6 months but could be less if client is discharging). Staff should make every effort to collect accurate information regarding change in client income levels however, if this information cannot be obtained, staff should mark the "Unknown" circle.

Project Services: This item will be completed semi-annually and at discharge. The section is **not** completed at admission. Staff will select the item that most closely describes the services the client has received from the Supportive Housing Project up to the time of the data collection.

Previous Living Situation: On the admission Face Sheet, staff will skip this item. On the semi-annual and the discharge Face Sheets, the staff will select the description that best describes the client's living situation in the

prior 6 months and enter the appropriate letter in the box under "Previous Living Situation."

Current Living Situation: Staff will select the description that best describes the client's living situation at the time of administration of the form (i.e., distribution date) and enter the appropriate letter in the box under "Current Living Situation." Note that if the client has not changed his/her living situation since the last assessment, both current and previous living situation items will be coded the same.

Previous Tenancy Status: On the admission Face Sheet, staff will **skip** this item. On the semi-annual and the discharge Face Sheets, the staff will select the status that best describes the client's previous tenancy status and fill-in the corresponding circle.

Current Tenancy Status: Staff will select the description that best describes the client's current tenancy status and fill-in the corresponding circle. Current refers to the client's status at the time of the scheduled administration (i.e., distribution date).

If Client has Moved: Staff will select the description that best describes the type of move a client has made (to more independent living, to more restrictive housing, or to an area out of the county). Staff will also identify whether this move was made against provider advice. This item is only to be completed if a client has moved since the completion of the prior administration of this instrument.

Report Data to DMH

Within 2 weeks after the Face Sheet is completed, staff will need to input the data on the DMH secure internet web entry forms (refer to the "Data Collection & Reporting" Section on Page 6).

Obtaining Forms

The State DMH will provide a clean copy of the Face Sheet to the project evaluator. The project evaluator will make clear copies of the Face Sheet to distribute to staff.

Draft

Supportive Housing Iniative Act (SHIA 2001)
Face Sheet

CLIENT ID NUMBER (Use CSI number - if none, use SSN)

0 1 2 3 4 5 6 7 8 9 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Client Ethnicity:
- ○ White/Caucasian
- ○ Hispanic
- ○ African American
- ○ Asian/Pacific Islander
- ○ Filipino
- ○ Native American
- ○ Other
- ○ Unknown

Client Age

1 2 3 4 5 6 7 8 9 0

Client's Gender
- ○ Male
- ○ Female
- ○ Unknown

Assessment Type
- ○ Existing
- ○ Admission
- ○ Semi-Annual
- ○ Discharge
- ○ Refused to Participate
- ○ Screened Out
- ○ Deceased

Project Code

1 2 3 4 5 6 7 8 9 0

Distribution Date

1 2 3 4 5 6 7 8 9 0

Marital Status
- ○ Currently Married
- ○ Currently Divorced
- ○ Currently Widowed
- ○ Single, Never Married
- ○ Other
- ○ Unknown

Status of Children
- ○ None/No Children
- ○ Living with Client
- ○ Not Living with Client
- ○ Unknown

Client's Primary Mental Health Diagnosis
- ○ Schizophrenia or other Psychotic Disorders
- ○ Mood disorders (i.e., major depressive or bipolar disorders)
- ○ Anxiety/Other Disorders
- ○ No Mental Health Disorder
- ○ Unknown

Substance Abuse Diagnosis
- ○ Problems With Alcohol
- ○ Problems With Drugs
- ○ Problems With Both Alcohol and Drugs
- ○ Not Applicable - No Alcohol or Drug Problems
- ○ Unknown

Is the client an immigrant to the United States?

○ Yes ○ No ○ Unknown

If "yes", how long has s/he been in the United States?

○ Less than 2 Years ○ 6 - 10 Years ○ Unknown
○ 2 - 5 Years ○ More than 10 Years

1. *Client's Special Needs:*

	Yes	No	Unk
a. Severe and persistent mental illness	○	○	○
b. Substance abuse problem	○	○	○
c. Developmental disabilities	○	○	○
d. Physical Disabilities or other chronic health conditions (e.g., quadripelegic, blind)	○	○	○
e. Military Veteran	○	○	○
f. HIV/AIDS	○	○	○
g. TANF client	○	○	○
h. Foster care client aging out of foster care	○	○	○
i. Transitional Age Youth	○	○	○
j. Exiting jail/prison	○	○	○
k. Other: (please specify)	○	○	○

2. *History of Chronic Physical Health Problems*
- ○ Minor chronic physical health problems that cause minimal impairment in functioning (e.g., mild asthma, epilepsy, hearing problem corrected with a hearing aid).
- ○ Moderate physical health problems which cause some difficulty in functioning (e.g., moderate hypertension, mild cerebral palsy; problem requires medical follow-up several times a year).
- ○ Serious chronic physical health problems which causes serious impairment in mobility, speech, vision, etc, despite use of glasses, hearing aids, etc.
- ○ Major physical health problems - confined to bed or wheelchair most of the time (e.g., advanced cancer, cerebral palsy).
- ○ Not Applicable - no chronic physical health problem
- ○ Unknown

Client ID Number (Must be entered on each page and is used to link pages)

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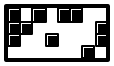

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3. ***History of Homelessness:***

- ○ Previously homeless, currently at risk for homelessness
- ○ Never homeless, currently at risk for homelessness
- ○ Homeless, first experience, homeless less than one year
- ○ Homeless, homeless several times before
- ○ Homeless for long period of time (i.e., more than one year)
- ○ Unknown

4. ***History of Mental Health Treatment***

- ○ No history of treatment despite presence of mental illness
- ○ Some experience with mental health services
- ○ Prior hospitalization or inpatient services
- ○ Lengthy experience with Mental Health services, but no hospitalization
- ○ Lengthy experience with Mental Health services, including hospitalization
- ○ Not applicable - no mental health problem
- ○ Unknown

5. ***History of Substance Abuse Problems***

- ○ Minor substance abuse problems, no treatment history
- ○ Serious substance abuse problems, no treatment history
- ○ Substance abuse problems with some involvement in a treatment program
- ○ Substance abuse problems with repeated involvement in treatment programs
- ○ Not Applicable - No substance abuse problems
- ○ Unknown

6. ***Criminal History***

- ○ Minor arrest history - nuisance offenses (drunk, disturbing peace, etc.)
- ○ Several arrests (misdemeanor) and time spent in jail
- ○ Serious arrests (felony) and spent time in jail/probation
- ○ Serious arrests (felony) and spent time in state prison
- ○ Not Applicable - No involvement with the criminal justice system
- ○ Unknown

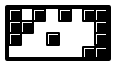
7. ***Employment History***

- ○ Minimal employment history (e.g., a few part time jobs, or one full time job)
- ○ Sporadic work history (e.g., mixture of full time jobs or part-time jobs and periods of unemployment)
- ○ Substantial work history (e.g., worked several years at a full time job, or several full time jobs in the same field)
- ○ None (never employed)
- ○ Unknown

Client ID Number (Must be entered on each page and is used to link pages)

SHIA Face Sheet Page 2 of 4

Draft



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8a *Client Employment Status (choose one)*

○ **Client is employed in the competitive job market**

If yes, approximately how many hours per week:

○ Less than 35 ○ 35 or more ○ Unknown

○ **Client is employed in the noncompetitive job market (sheltered workshop, protected environment)**

If yes, approximately how many hours per week:

○ Less than 35 ○ 35 or more ○ Unknown

○ **Client is not in the job market. Client is (choose one)**

- ○ Actively looking for work
- ○ Homemaker
- ○ Student
- ○ Volunteer Worker
- ○ Retired/on disability
- ○ Resident/inmate of institution
- ○ Other
- ○ Client employment status is unknown
- ○ Unknown

8b *Client Income (choose all that apply)*

Client Sources of Income

	YES	NO	Unknown
Supplementary Security Income (SSI)	○	○	○
General Assistance	○	○	○
Social Security	○	○	○
Wages	○	○	○
Other	○	○	○

8c *Change in Client Income (if admission assessment, skip item)*

- ○ Income Increased
- ○ Income Stayed the Same
- ○ Income Decreased
- ○ Unknown

9. Services client has received from this Supportive Housing Project since the last assessment (if admission assessment, skip this section):

	YES	NO	Unknown
Client Declined Any Services *(If "yes" is selected, skip the rest of this section.)*	○	○	○
Employment Services	○	○	○
Referral to Community Mental Health Services	○	○	○
Screening and Diagnostic Services	○	○	○
Referral to Drug/Alcohol Treatment Services	○	○	○
Referral to Regional Center	○	○	○
Referral to Medical Specialist	○	○	○
Case Management Services	○	○	○
Planning For/Referral To Housing	○	○	○
Assistance In Applying for Housing	○	○	○
Helped Client Obtain Housing (e.g., assistance in filling out lease agreement; help with deposit)	○	○	○
Assistance In Maintaining Housing (e.g., assistance to prevent eviction)	○	○	○

Client ID Number (Must be entered on each page and is used to link pages)

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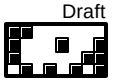

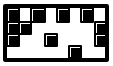

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10a. **Client's Previous Living Situation (at time of last assessment or prior to admission) (Select code from list below)**

☐

10b. **Client's Current Living Situation (select code from list below)**

☐

- **A** House or apartment (include trailers, hotels, dorms, barracks, etc.)
- **B** House or apartment and requiring some support with daily activities
- **C** House or apartment and requiring daily support and supervision
- **D** Supported housing
- **E** Foster family home
- **F** Group Home (includes levels 1-12 for children)
- **G** Residential Treatment Center (includes levels 13-14 for children
- **H** Community Treatment Facility
- **I** Board and Care
- **J** Adult Residential Facility, Social Residential Facility, Crisis Residential, Traditional Residential, Drug Facility, Alcohol Facility
- **K** Mental Health Rehabilitation Center (24 hour)
- **L** Skilled Nursing Facility/Intermediate Care Facility, Institute of Mental Disease (IMD)
- **M** Inpatient Psychiatric Hospital, Psychiatric Health Facility (PHF), or Veterans Affairs Hospital
- **N** State Hospital
- **O** Justice related (Juvenile Hall, CYA home, correctional facility, jail, etc.)
- **P** Homeless, no identifiable residence
- **Q** Other
- **U** Unknown/Not reported

11a. **Previous Tenancy Status (at time of last assessment or prior to admission)**

- ○ Continuing
- ○ Evicted due to lease violations
- ○ Left voluntarily
- ○ Jailed
- ○ Hospitalized
- ○ Unknown

11b. **Current Tenancy Status (at time of this assessment)**

- ○ Continuing
- ○ Evicted due to lease violations
- ○ Left voluntarily
- ○ Jailed
- ○ Hospitalized
- ○ Unknown

11c. **If client has moved, select one of the following.** ***Client moved to*:**

- ○ more independent housing
- ○ more restrictive housing
- ○ Area out of county
- ○ Unknown

11d. **If client has moved, was it against provider advice?**

○ Yes ○ No ○ Unknown

Client ID Number (Must be entered on each page and is used to link pages)

SHIA Face Sheet Page 4 of 4

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Chapter 5
California Quality Of Life
(CA-QOL)

General Information
The California Quality Of Life (CA-QOL) measures the client's satisfaction with his or her quality of life. The eight domains covered include general life satisfaction, living situation, daily activities and functioning, family, social relations, finances, legal and safety, and health. The form is designed to be completed by the client in approximately 20 minutes.

Development
The CA-QOL was developed in response to a need in another DMH project (The Adult Performance Outcome System) for a self-administered quality of life assessment instrument in the public domain. DMH obtained permission from Dr. Anthony Lehman to select and modify items from two of his instruments, Lehman's Quality of Life Long Interview and Lehman's Quality of Life Brief Interview. A committee composed of representatives from California's Department of Mental Health, Project Mental Health programs, California Mental Health Planning Council, and additional consultants was formed to develop a short self-administered quality of life assessment instrument. The CA-QOL was constructed statistically from items in Lehman's two instruments. After its development, the form was pilot tested. The CA-QOL, in combination with information from the state DMH CSI system, measures the same domains as Lehman's self-administered form (Lehman's QOL-SF).

Psychometrics
The psychometric properties, reviewed during the pilot testing for the Adult Performance Outcome Pilot Evaluation, are acceptable. See Appendix B for a review of psychometric concepts.

Reliability: The overall reliability of the CA-QOL is high (.93). The reliability of all CA-QOL subjective scales is relatively high (.84 to .93), while the reliability of the three CA-QOL objective scales with more than 1 item is modest (.67 to .75). The reliability coefficients of the same three objective subscales are also modest (.73-.76).

Validity: The CA-QOL was developed from two of Lehman's Quality of Life forms and these two forms have demonstrated validity. By extrapolation, the CA-QOL is assumed to be valid.

Differential Functioning: An analysis of subscale scores by demographic category indicated statistically significant differences at the .05 level. These differences, although significant, were deemed minor because they accounted for only 10% of the variance.

Diagnoses combined: When all diagnoses were combined, statistically significant differences were found, but these were minor.

Within Diagnoses: When stratified by diagnoses, statistically significant differences were found. For Diagnosis 1 (Schizophrenia/Psychotic Diagnoses), there were significant differences for the category age on two scales: "General Life Satisfaction" and "Satisfaction with Living Situation." Post hoc tests did not pinpoint these differences as explained above. However, the youngest and oldest groups had higher mean scores than did the intermediate age categories.

For Diagnosis 2 (Mood Disorders), there were statistically significant differences on three objective scales. Differences were found for age for "Amount of Spending Money." Clients in the youngest age category reported having less money to spend on themselves than did clients in the other age categories. There were also differences on "Adequacy of Finances." The youngest and oldest age categories reported having the least money for various items. It is possible that these differences could be an artifact of low numbers.

There was a meaningful difference found for ethnicity on "General Health Status." Although post hoc tests did not pinpoint these differences, Asians tended to have the highest mean scores and Caucasians the lowest mean scores. It is possible that these differences could be an artifact of low numbers.

Scoring

Scoring of the CA-QOL is relatively straightforward. Items can be scored individually or as part of a scale score. Computing scale scores consists primarily of calculating averages for scales with more than one item. There are two types of items: subjective items and objective items. All subjective items use the same 7-point scale. Objective items use a variety of formats. Scale scores can be computed for each type. An overall quality of life score would not be appropriate because of the varying item content and format.

The specific items comprising each of the scales can be found in the "Scoring Manual for the California Quality Of Life," which is included at the end of this chapter.

Clinical Utility

The CA-QOL provides a relatively brief, structured way to assess self-reports of the quality of life for persons with severe mental illness. The instrument provides both an objective measure about a quality of life indicator as well as the client's

subjective feelings of satisfaction about that indicator. The CA-QOL results can provide useful information for assessment and treatment planning, e.g., assessing a client's satisfaction with qualify of life, developing a baseline for satisfaction with quality of life, etc.

Administration Procedures

The CA-QOL is completed at every data collection, i.e., at admission, every six months, and at discharge. The project evaluator will complete the top portion of the form by filling in the fields for "Client ID Number," "Distribution Date," and "Project Code." Also, the Client ID should be entered in eight of the boxes at the bottom left-hand corner of each page of the form. These items are completed in the same way as on the Face Sheet, see Chapter 4, "Administration Procedures." After this is completed, the project evaluator will give the form to project staff so they can give it to the client to complete.

Staff Administration

Within the first 60 days following admission, project staff will give the CA-QOL to the client to complete. This form takes approximately 18 minutes for clients to complete on their own. In the pilot test, 60% completed the instrument without assistance, approximately one-quarter required some assistance (23%), and 15% required total interviewer administration.

When the client has completed the form, staff will need to input the data on the DMH secure internet web entry forms (refer to the "Data Collection & Reporting" Section on Page 6).

Client Computerized Self-Administration

If a client is capable of doing so, projects may have clients directly input the data for a paperless, computerized self-administration of this instrument. Staff would need to set up the computer entry system and enter the "Client ID Number," "Distribution Date," and "Project Code."

Overlap with Performance Outcome Project

The CA-QOL is being used for the Performance Outcome project so it is possible that a client will have a recently completed CA-QOL in file. If the CA-QOL has been completed for the client within 30 days of the distribution date, the staff may input this data onto the secure web site and not re-administer the form.

Discharged Client Unavailable

There will be times when a client is discharged because she/he has left the program without advance warning and is unavailable to complete the CA-QOL. Some of these clients will simply disappear; others will be incarcerated or hospitalized. Every attempt should be made to get all the forms completed. However, if the client is unavailable, the CA-QOL will not be collected.

Obtaining Forms

The State DMH will provide a clean copy of the CA-QOL to the project evaluator. The project evaluator will make clear copies of the CA-QOL to distribute to staff.

Scoring Manual

for the

California Quality of Life (*CA-QOL*)

Prepared by the California Department of Mental Health
Research and Performance Outcome Development Section

Table of Contents

Tables

ACKNOWLEDGMENTS

The California Department of Mental Health would like to express its appreciation to the California Mental Health Directors Association and the California Mental Health Planning Council for their support and assistance in the development and implementation of the Adult Performance Outcome System, of which this manual is a part. Additionally, we would like to express our gratitude to the leadership, staff, and mental health consumers of Sacramento and San Mateo counties for their assistance in the development of the California Quality of Life (*CA-QOL*) Survey. We would also like to thank Dr. Anthony Lehman, Department of Psychiatry, University of Maryland, for his permission to use items from his public domain quality of life instruments in order to develop a survey instrument particularly suited to California's needs.

For more information about the *CA-QOL* contact:

California Department of Mental Health
Research and Performance Outcome Development Unit
1600 9th Street
Sacramento, California 95814

Scoring Manual for the California Quality of Life

I. BACKGROUND

Introduction

Under the leadership of the State Department of Mental Health (DMH), the California Mental Health Planning Council (CMHPC), and the California Mental Health Directors Association (CMHDA), a pilot project was conducted to assess instruments for use in California's Adult Performance Outcome System. The recommendation that resulted from this pilot was that the following instruments be selected for statewide implementation: the Global Assessment of Functioning (*GAF*) Scale, the Behavior and Symptom Identification Scale (*BASIS-32*), a quality of life survey instrument, and a consumer satisfaction program evaluation instrument. Further meetings regarding a quality of life instrument resulted in the selection of the *QL-SF* (formerly called the *TL-30S*), Dr. Anthony Lehman's shorter, self-administered quality of life instrument. Additionally, in order to respond to subsequent questions about the availability and cost of the *QL-SF* and to provide greater flexibility to the counties, the DMH, CMHPC, and CMHDA agreed to develop an alternative, self-administered, public domain quality of life instrument (the California Quality of Life or *CA-QOL*). If the *CA-QOL* proved sufficiently comparable to the *QL-SF*, counties could, at their discretion, choose to use either quality of life instrument for the Adult Performance Outcome System.

Development of the *CA-QOL*

DMH obtained written permission from Dr. Lehman to select and modify items from his public domain Quality of Life Interview Instruments (*QOL-Brief* and *QOL-Long*) in order to develop a new quality of life instrument particularly suited to California's needs. A small committee of representatives from DMH, CMHPC, and CMHDA then developed a draft of the new quality of life instrument, the *CA-QOL*, extracting items from both the *QOL-Brief* and *QOL-Long*.

The *CA-QOL* consists of 40 items and measures the same domains as the *QL-SF* when supplemented with information from DMH's Client Services Information (CSI) data system. In order to minimize the data collection burden on counties, while measuring the CMHPC domains, the committee agreed to obtain as much data as possible from the CSI system.

Pilot Methodology

Two counties (Sacramento and San Mateo) volunteered to administer both quality of life instruments to a sample of seriously mentally ill adult mental health clients. The counties attempted to obtain a heterogeneous sample with particular emphasis on obtaining adequate numbers of both men and women. Information was also gathered on the client's ethnicity and age, as well as primary diagnosis within broad categories. Categories of diagnosis found to be useful in the previous pilot were: (1) schizophrenia and other psychotic disorders, (2) mood disorders, and (3) anxiety and other diagnoses. Pilot protocols were developed and distributed before the counties began administering the instruments. These protocols addressed clinician training, instrument administration issues, and data collection and reporting issues

Pilot Results

Both instruments were administered in a rotated order to a sample of 198 seriously mentally ill adult mental health clients. In general, pilot participants included adequate numbers within age categories, major ethnic groups, gender, and the two major diagnostic categories to allow for statistical analysis. There was little missing data.

Most client participants were able to complete either of the instruments without assistance (approximately 60%). Approximately 23% of the clients required some assistance and only about 15% required total interviewer administration. On average, it took clients 20 minutes to complete the *QL-SF* and 18 minutes to complete the *CA-QOL*. The range of reported times for both instruments was from about five minutes to as long as one hour. Approximately 75% of
the clients were able to complete either instrument in 20 minutes or less, and approximately 90% of the clients were able to complete either instrument in 30 minutes or less. Completion times for both instruments could vary considerably depending on the client's level of functioning.

In general, average scores on corresponding scales were quite similar and correlated well. An analysis of scale scores by demographic category indicated only minor statistically significant differences.

Based on an internal consistency measure of reliability (Cronbach's alpha), the overall reliability of the *CA-QOL* was found to be high (.93), while the overall reliability of the *QL-SF* was lower (.70). The reliability of the three *CA-QOL objective* scales with more than one item was modest, as was the reliability of the same three *QL-SF* objective subscales. The reliability of all *CA-QOL subjective* scales was relatively high. The reliability of *QL-SF* subjective scales can only be computed for the two items which make up the "General Life Satisfaction" scale, and it was slightly lower than for same two items on *CA-QOL*. Internal consistency coefficients of reliability cannot be computed for any other *QL-SF* subjective scales since the other scales have only one item.

Both instruments were based on Lehman's *QOL-B and QOL-L* instruments, which have demonstrated validity and reliability. By extrapolation, it is assumed that the *QL-SF* and *CA-QOL* are valid. Additionally, the instruments are assumed to be valid for purposes of the California Adult Performance Outcome System because they measure what they are supposed to measure; i.e., the CMHPC quality of life domains.

For more detailed information on statistical results, a copy of the summary report entitled "A Pilot to Evaluate Alternative Quality of Life Assessment Instruments," can be obtained by writing the California Department of Mental Health, Research and Performance Outcome Development Unit, 1600 9th Street, Sacramento, California, 95814.

Conclusions of Pilot

In many ways the instruments are similar:

- Both instruments provide a relatively brief, structured way to assess the quality of life of persons with severe mental illness.
- Both instruments are based on Lehman's public domain quality of life instruments and, as a result, item content and format are similar.
- When combined with the CSI data system, both instruments adequately measure the quality of life domains which are of interest to the CMHPC.

- The completion time required and assistance needed were similar for both instruments.

- There was little differential impact within scales of either instrument.

- Mean scores are quite similar for corresponding scales, and correlations between these scales are generally high. No meaningful differences were found between scale scores across instruments. Scores from the *QL-SF* can be statistically equated to those on the *CA-QOL* using regression techniques.

In some ways the CA-QOL has advantages for California:

- The *CA-QOL* is in the public domain. This not only eases the financial burden on counties, but makes it possible to revise the instrument's format or develop language translations to meet California's needs.

- An analysis of the psychometric properties of the *CA-QOL* indicates it compares very favorably with the *QL-SF*. It is somewhat faster to complete, and its overall and scale reliability based on internal consistency is better.

- The *CA-QOL* minimizes the data collection burden on counties, while still measuring the CMHPC domains, by obtaining as much data as possible from California's CSI data system. However, although this eliminates redundant questions, it also limits the instrument's usefulness for national comparisons because certain data elements are missing.

- Although both instruments, when combined with CSI data, measure the same CMHPC domains, the *CA-QOL* provides more complete information on the subjective, client satisfaction scales.

The purpose of the pilot was to determine whether the *CA-QOL* and *QL-SF* could be equated and to analyze the psychometric properties of the two instruments. After a review of the initial pilot results, the conclusion of this project is that the *CA-QOL* can serve as a valid alternative to the *QL-SF*. Additional data are still being gathered and will be appended when they are available.

II. GENERAL GUIDELINES

Clinical Integration

The key to the successful implementation of the adult performance outcome measurement system is effective clinical integration of the performance outcome instruments. The *CA-QOL* is one part of a set of instruments. The information provided by the set of outcome instruments can furnish valuable clinical information. However, unless clinicians understand how to interpret and integrate this information into the diagnosis, treatment planning, and service provision process, the data will not be used effectively.

The results of the adult performance outcome instruments are not intended to replace the skills used by clinicians to complete a thorough evaluation, design a treatment plan, or monitor progress. Many of the questions are similar to the questions clinicians already ask as part of their clinical assessment. However, asking these questions in a standardized format, in combination with clinical assessment skills and additional data sources, gives a more comprehensive and objective clinical profile of an individual client.

Uses

The *CA-QOL* results can provide useful information for assessment and treatment planning (e.g., assessing a client's satisfaction with quality of life, developing a baseline for satisfaction with quality of life, identifying areas of strength or weakness, and developing a treatment plan). The *CA-QOL* results can also be useful for monitoring/evaluating progress, identifying a need for additional resources, and evaluating the effectiveness of treatment.

Administration

The *CA-QOL* should be administered along with the other assessment instruments at intake (once a client has been determined to be part of target population), semi-annually, and at discharge. The Adult Performance Outcome Training Manual gives more specific information on administration procedures for the adult performance outcome instruments.

A copy of the Adult Performance Outcome Training Manual can be obtained by writing the California Department of Mental Health, Research and Performance Outcome Development Unit, 1600 9th Street, Sacramento, California, 95814.

As indicated earlier, the *CA-QOL* was intended to be administered as a self-report, but the pilot found that assistance may be required. This assistance does not necessarily have to be provided by the clinician.

III. SCORING THE *CA-QOL*

Scoring of the *CA-QOL* is relatively straightforward. Items can be scored individually or as part of a scale score. Computing scale scores consists primarily of calculating averages for scales with more than one item. There are two types of items: subjective items and objective items. All subjective items use the same 7-point scale. Objective items use a variety of formats. Scale scores can be computed for each type. An overall quality of life score would not be appropriate because of the varying item content and format.

The specific items comprising each of the scales are listed in Table 1 below. *Note*: scoring of the alternate quality of life instrument, the *QL-SF*, is also relatively simple. Counties selecting the *QL-SF* can obtain a scoring manual by contacting Deborah Rearick of HCIA/Response at (781) 522-4630 or writing HCIA/Response Technologies at 950 Winter Street, Waltham, MA, 02451.

Missing Data

Scale scores should not be computed if there are any missing data for that scale. Because most scales are composed of no more than two or three items, even a single non-response to the items in that scale significantly affects an aggregated score.

Subjective Scales

All of the items measuring subjective scales use the same 7-point ordinal scale. Respondents should mark only one answer for each item. Items should be coded as indicated in Table 1.

Table 1
Coding for Subjective Scales

Subjective Scales	Items	Coding for Subjective Items
General Life Satisfaction Satisfaction with Living Situation Satisfaction with Leisure Activities Satisfaction with Daily Activities Satisfaction with Family Relationships Satisfaction with Social Relations Satisfaction with Finances Satisfaction with Safety Satisfaction with Health	1, 17 2a, 2b, 2c 3b, 3c, 3d 3a 6a, 6b 8a, 8b, 8c, 8d 11a, 11b, 11c 14a, 14b, 14c 16a, 16b, 16c	1 = Terrible 2 = Unhappy 3 = Mostly Dissatisfied 4 = Mixed 5 = Mostly Satisfied 6 = Pleased 7 = Delighted

In order to obtain the scale score, simply compute the average of all of the items listed next to each scale. For example, for the scale "Satisfaction with Living Situation," assume that a consumer marks a score of **4** on Item 2a, a score of **5** on Item 2b, and a score of **6** on Item 2c. The average of these three scores would be the sum of 4 + 5 + 6 (which is 15) divided by 3 for an average (mean) score of 5. "Daily Activities" is the only area in which an average cannot be computed since it consists of only one item.

Objective Scales

As mentioned previously, certain objective categorical information necessary to measure CMHPC outcome domains is already being gathered by the CSI data system and was not included in the *CA-QOL*. These two areas are: Type of Living Situation and Types of Productive Activities (e.g., work, education, volunteering). The *CA-QOL* does gather subjective information about these domains. The items measuring the remaining seven objective scales come in a variety of formats and should

be coded as described in Table 2. As noted previously, these items can be scored individually or combined into scale scores where appropriate (for scales with more than one item).

Note that item number 13 (number of arrests) and item number 15 (health status) are coded so that higher values are a negative outcome. On all other items, higher values indicate a positive outcome.

Table 2
Coding for Objective Scales

Objective Scales	Items	Coding for Objective Items	Scale Scores
Frequency of Family Contacts	4, 5	0 = no family 1 = not at all 2 = less than once a month 3 = at least once a month 4 = at least once a week 5 = at least once a day	Compute mean (excluding those responding 0)
Frequency of Social Contacts	7a, 7b, 7c, 7d	1 = not at all 2 = less than once a month 3 = at least once a month 4 = at least once a week 5 = at least once a day	Compute mean
Amount of Spending Money	9	1 = less than $25 2 = $25 to $50 3 = $51 to $75 4 = $76 to $100 5 = more than $100	Single score
Adequacy of Finances	10a, 10b, 10c, 10d 10e	0 = No 1 = Yes	Compute percent yes/no
Victim of Crime	12a, 12b	0 = No 1 = Yes	Compute percent yes/no
Arrested	13	0 = 0 arrests 1 = 1 arrests 2 = 2 arrests 3 = 3 arrests 4 = 4 arrests 5 = 5 arrests 6 = 6 arrests	Single score Note: for this item high scores are a negative outcome.
General Health Status	15	1 = excellent 2 = very good 3 = good 4 = fair 5 = poor	Single score

Supportive Housing Iniative Act (SHIA 2001)
California Quality of Life (CA-QOL)*

26516

Client ID Number

0 1 2 3 4 5 6 7 8 9 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Distribution Date

__ - __ - ____

Project Code

0 1 2 3 4 5 6 7 8 9

Instructions: Below is a set of questions about your life. Please answer each question by filling in the bubble that best describes your experience or how you feel. Please fill in only one bubble for each question.

General Life Satisfaction

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
1. How do you feel about your life in general?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Living Situation

2.Think about your current living situation. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The living arrangements where you live?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. The privacy you have there?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The prospect of staying on where you currently live for a long period of time?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Daily Activities & Functioning

3.Think about how you spend your spare time. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The way you spend your spare time?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. The chance you have to enjoy pleasant or beautiful things?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The amount of fun you have?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
D. The amount of relaxation in your life?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Client ID Number (Must be entered on each page and is used to link pages)

*Adapted from the Full and Brief versions of the Lehman Quality of Life Interview.

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Family

4. In general, how often do you talk to a member of your family on the telephone?

○ at least once a day ○ at least once a month ○ not at all
○ at least once a week ○ less than once a month ○ no family

5. In general, how often do you get together with a member of your family?

○ at least once a day ○ at least once a month ○ not at all
○ at least once a week ○ less than once a month ○ no family

6. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The way you and your family act toward each other?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. The way things are in general between you and your family?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Social Relations

7. About how often do you do the following?

A. Visit with someone who does not live with you?

○ at least once a day ○ at least once a month ○ not at all
○ at least once a week ○ less than once a month

B. Telephone someone who does not live with you?

○ at least once a day ○ at least once a month ○ not at all
○ at least once a week ○ less than once a month

C. Do something with another person that you planned ahead of time?

○ at least once a day ○ at least once a month ○ not at all
○ at least once a week ○ less than once a month

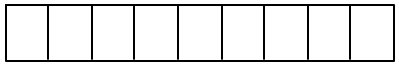
D. Spend time with someone you consider more than a friend, like a spouse, a boyfriend or a girlfriend?

○ at least once a day ○ at least once a month ○ not at all
○ at least once a week ○ less than once a month

8. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The things you do with other people?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. The amount of time you spend with other people?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The people you see socially?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
D. The amount of friendship in your life?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Client ID Number (Must be entered on each page and is used to link pages)



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Finances

9. On average, how much money did you have to spend on yourself in the past month, not counting money for room and meals?

○ less than $25 ○ $25 to $50 ○ $51 to $75 ○ $76 to $100 ○ more than $100

10. During the past month, did you generally have enough money to cover the following items?

	No	Yes
A. Food?	○	○
B. Clothing?	○	○
C. Housing?	○	○
D. Traveling around for things like shopping, medical appointments, or visiting friends and relatives?	○	○
E. Social activities like movies or eating in restaurants?	○	○

11. In general, how do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. The amount of money you get?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. How comfortable and well-off you are financially?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The amount of money you have available to spend for fun?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

Legal & Safety

12. In the past month, were you a victim of:

	No	Yes
A. Any violent crimes such as assault, rape, mugging, or robbery?	○	○
B. Any nonviolent crimes such as burglary, theft of your property or money or being cheated?	○	○

13. In the past month, have you been arrested or picked-up for any crimes?

○ *0 arrests* ○ *1 arrest* ○ *2 arrests* ○ *3arrests* ○ *4 arrests* ○ *5arrests* ○ *6 or more arrests*

14. How do you feel about:

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. How safe you are on the streets in your neighborhood?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
B. How safe you are where you live?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7
C. The protection you have against being robbed or attacked?	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7

26516

Health

15. In general, would you say your health is:

◯ **excellent** ◯ **very good** ◯ **good** ◯ **fair** ◯ **poor**

16. How do you feel about:	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
A. Your health in general?	◯ **1**	◯ **2**	◯ **3**	◯ **4**	◯ **5**	◯ **6**	◯ **7**
B. Your physical condition?	◯ **1**	◯ **2**	◯ **3**	◯ **4**	◯ **5**	◯ **6**	◯ **7**
C. Your emotional well-being?	◯ **1**	◯ **2**	◯ **3**	◯ **4**	◯ **5**	◯ **6**	◯ **7**

Global Rating

	Terrible	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Pleased	Delighted
17. How do you feel about your life in general?	◯ **1**	◯ **2**	◯ **3**	◯ **4**	◯ **5**	◯ **6**	◯ **7**

18. How did you become involved with this program?

◯ **I decided to come in on my own.**

◯ **Someone else recommended that I come in.**

◯ **I came in against my will.**

The California Quality of Life Survey (CA-QOL) is adapted from Dr. Anthony Lehman's Quality of Life Interview (Full and Brief versions) by a committee representing the State Department of Mental Health, California Mental Health Directors Association, and the California Mental Health Planning Council with the written permission of Dr. Lehman. Questions about the CA-QOL should be directed to the California Department of Mental Health, 1600 9th Street, Sacramento, CA, 95814. For more information about the Lehman Quality of Life Interview, contact: Anthony Lehman, M.D., Department of Psychiatry, University of Maryland Medical Center, 645 West Redwood Street, Baltimore, MD 21201.

Client ID Number (Must be entered on each page and is used to link pages)

26516

Chapter 6
Mental Health Statistics Improvement Program (MHSIP) Consumer Survey

General Information

The Mental Health Statistics Improvement Program (MHSIP) Consumer Survey is a public domain instrument that was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program community, and the Center for Mental Health Services. The MHSIP Consumer Survey measures the client's general satisfaction with program services, access to services, appropriateness of treatment, and outcomes of care. The form is designed to be completed by the client in approximately 10 minutes. For the purposes of the Supportive Housing Initiative, a few questions were re-worded to be more general, making the instrument less focused on mental health and more general in its questioning.

Development

The original 40-item MHSIP Consumer Survey was piloted by five states. Based on guidance from the NCQA Behavioral Measurement Advisory Panel, a shorter 21-item version of the instrument was developed. The reduced item set was obtained by using an algorithm that selected items on the basis of their unique contribution to a domain in combination with logical and exploratory factor analytic procedures. DMH added 4 questions to the 21-item form. These included changes in wording to make it more applicable to the California setting and the addition of certain items important to consumers, resulting in a 26-item version.

Psychometrics

The MHSIP Task Force has reported that the 21-item version has psychometric features similar to the original 40-item version. In the five-state study, the reliability coefficients for the domain scales ranged from .65 to .87. The 26-item version is expected to have similar psychometric properties. See Appendix B for a review of psychometric properties.

Scoring

Respondents rate their level of agreement or disagreement with each of the first 26 statements on a scale with values ranging from strongly agree to strongly disagree, and not applicable. The average percentage score for each domain is calculated (domains are access, appropriateness, outcomes and satisfaction with services) and these scores are used to

compare programs on these measures. Table 7-1 shows the items that are scored for each domain. As noted earlier, several items were reworded slightly to accommodate those projects and clients that are not mental health programs. For example, question number 17 originally said "Staff and I worked together to plan my treatment." It was revised to say "Staff and I worked together to plan my treatment and/or services."

TABLE 6.1 MHSIP CONSUMER SURVEY DOMAINS

DOMAINS	ITEM NUMBERS
Access	4, 5, 6, 7, 8, 19
Appropriateness	9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Outcomes	20, 21, 22, 23, 24, 25, 26
Satisfaction	1, 2, 3

Clinical Utility

The MHSIP Consumer Survey is not a clinical instrument. It can provide valuable information about client's views on program services.

Confidentiality

Client confidentiality must be assured as part of the process of collecting consumer satisfaction data. Therefore, it is recommended that when a client is sent or handed a satisfaction survey, a notice of confidentiality of data be included to reassure the client.

To encourage accurate responses, it is crucial that respondents to the *MHSIP Consumer Survey* be assured confidentiality of their responses so they will not have any fear of retribution. Clinical/Service Provider staff should never administer these forms, never assist clients in completing these forms, nor should they see the results of client satisfaction instruments (except at an aggregated level) to preserve client confidentiality. It is recommended that it be placed in a sealed envelope after completion by the respondent. Clinicians and other service providers should only receive aggregate summary data.

A project may want to provide an "Assurance of Confidentiality" letter along with the instrument when given to the respondents. The following is an example of the text of such a letter:

> "This letter is to assure you as a client receiving services through [*insert your agency name*] that the MHSIP Consumer Survey that you are about to fill out is confidential. Your service providers will not see this and your responses in no way affect your right to services. Because [insert project name] will use the results to improve quality of service, we are interested in your honest opinions, whether they are positive or negative. Thank you for your cooperation and help in improving our service to you."

Administration Procedures

The MHSIP Consumer Survey will be completed after six months in the program, and every six months thereafter, as long as the client is receiving services in the program. It is also collected at discharge. If a client discharges before spending six months in the program, the MHSIP must be completed.

Before giving the form to the client, the project evaluator will write the client identification number, and the project code in the appropriate fields. Make sure the client ID is entered at the bottom left of each page of the form. The method for completing these items is described in Chapter 4, under "Administration Procedures."

Project Administration

Projects that have the resources available for non-clinical/non-service provider staff to administer the forms, input the data, and store the forms in a manner that preserves client confidentiality may process these forms themselves. ***Note: Clinical/Service Provider staff should never administer these forms, never assist clients in completing these forms, nor should they see the results of client satisfaction instruments (except at an aggregated level) to preserve client confidentiality.*** When the client has completed the form, non-clinical/non-service provider staff will need to input the data on the DMH secure internet web entry forms (refer to the "Data Collection & Reporting" Section on Page 6).

Client Computerized Self-Administration

If a client is capable of doing so, projects may have clients directly input the data for a paperless, computerized self-administration of this instrument. Staff would need to set up the computer entry system and enter the "Client ID Number," "Distribution Date," and "Project Code."

Providing Assistance to Client

If the client wants assistance in completing the instrument, clerical staff or peer counselors may assist with the mechanics of how to complete the form; however, actual responses to the questions should be made only by the consumer.

Discharged Client Unavailable

There will be times when a client is discharged because she/he has left the program without advance warning and is unavailable to complete the MHSIP Consumer Survey. Some of these clients will simply disappear; others will be incarcerated or hospitalized. Every attempt should be made to get all the forms completed. However, if the client is unavailable, the MHSIP Consumer Survey will not be collected.

Overlap with Performance Outcome Project

The MHSIP Consumer Report is being used by the Adult Performance Outcome project so it is possible that a client recently will have completed a MHSIP Consumer Report rating her/his mental health services. Since the Supportive Housing Project is separate from mental health services, the client will be asked to complete another MHSIP Consumer Report for the Supportive Housing Project.

Obtaining Forms

The State DMH will provide a clean copy of the MHSIP Consumer Survey to the project evaluator. The project Evaluator will make clear copies to distribute to staff.

Supportive Housing Iniative Act (SHIA 2001)
MHSIP Consumer Survey

This survey was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services.

INSTRUCTIONS: This survey will help us to improve our mental health services for you. Your answers will be kept confidential and will only be used to evaluate and improve the services here. Please indicate your agreement or disagreement with each of the statements below. Fill in the circle that best represents your opinion.

Client ID Number

0 1 2 3 4 5 6 7 8 9 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Distribution Date

__ - __ - ____

0 1 2 3 4 5 6 7 8 9

Project Code

0 1 2 3 4 5 6 7 8 9

	Strongly Agree 5	Agree 4	I am Neutral 3	Disagree 2	Strongly Disagree 1	Not Applicable 0
1. I like the services that I received here.	○	○	○	○	○	○
2. If I had other choices, I would still choose to get services from this agency.	○	○	○	○	○	○
3. I would recommend this agency to a friend or family member.	○	○	○	○	○	○
4. The location of services was convenient *(parking, public transportation, distance, etc.)*	○	○	○	○	○	○
5. Staff were willing to help as often as I felt it was necessary.	○	○	○	○	○	○
6. Staff returned my calls within 24 hours.	○	○	○	○	○	○
7. Services were available at times that were good for me.	○	○	○	○	○	○
8. I was able to get all the services I thought I needed.	○	○	○	○	○	○
9. Staff here believed that I could grow, change, and, where possible, recover.	○	○	○	○	○	○
10. I felt safe to raise questions or complain.	○	○	○	○	○	○
11. Staff told me what side effects to watch for, if applicable.	○	○	○	○	○	○
12. Staff respected my wishes about who is, and is not, to be given information about my treatment and/or supportive services.	○	○	○	○	○	○

Please Continue on Page 2

Client ID Number (Must be entered on each page and is used to link pages)

do not make any marks below this line

27325

2

	Strongly Agree 5	Agree 4	I am Neutral 3	Disagree 2	Strongly Disagree 1	Not Applicable 0
13. Staff were sensitive to my cultural/ethnic background.	○	○	○	○	○	○
14. Staff helped me so that I could manage my life and recover, where possible.	○	○	○	○	○	○
15. I felt that I was treated with respect by the receptionist.	○	○	○	○	○	○
16. I felt comfortable asking questions about my treatment, supportive services, and/or medication (if applicable).	○	○	○	○	○	○
17. Staff and I worked together to plan my supportive services, and/or treatment.	○	○	○	○	○	○
18. I, not staff, decided my supportive services and/or treatment goals.	○	○	○	○	○	○
19. I was given written information that I could understand.	○	○	○	○	○	○
As a Direct Result of Services I Received:						
20. I deal more effectively with daily problems.	○	○	○	○	○	○
21. I am better able to control my life.	○	○	○	○	○	○
22. I am better able to deal with crisis.	○	○	○	○	○	○
23. I am getting along better with my family.	○	○	○	○	○	○
24. I do better in social situations.	○	○	○	○	○	○
25. I do better in school and/or work.	○	○	○	○	○	○
26. My symptoms are not bothering me as much (if applicable).	○	○	○	○	○	○

27. How did you become involved with this program?

○ I decided to come in on my own.
○ Someone else recommended I come in.
○ I came in against my will.

28. What would you like to see changed about this program? (Write comments in box below)

29. Do you currently attend self-help?

○ Yes ○ Not Available ○ No

30. If YES, how often do you participate?

○ Daily ○ Weekly ○ Monthly ○ Occasionally ○ Not at all

do not make any marks below this line

Client ID Number (Must be entered on each page and is used to link pages)

SHIA 2001 MHSIP page 2 of 2

Draft

Chapter 7
Summary of Project Evaluator's Responsibilities

General Information
The project evaluator is the keystone of a successful evaluation of the Supportive Housing Initiative Project. This person has critical data collection and evaluation responsibilities, most of which have been described in previous chapters. This chapter provides a summary of each of the tasks that are the responsibility of the project evaluator.

Responsible for Project Data Collection
The project evaluator is the person designated by the project as the person responsible for the project's Supportive Housing evaluation efforts. As the "Point Person" for the project's evaluation efforts, the project evaluator is the person who will be contacted when there are problems with the project evaluation and who will be expected to resolve the issues.

Making Copies of The Manual
In preparation for training project staff on the administration of the instruments, the project evaluator will make copies of the Evaluator's Training Manual and the CA-QOL scoring manual.

Training Project Staff
Training project and clinical staff on the administration of the forms and the evaluation procedures is the next tasks for the project evaluator. Training the staff will, hopefully, help them understand the importance of their role in the data collection and will ensure accurate data. After training staff, the project Evaluator will send a letter to the State Evaluator that lists the persons trained to complete the forms.

Developing Client Tracking System
The project evaluator will need to develop a tracking system in order to identify when clients enter the program, and when they are due for a semi-annual assessment or a discharge assessment. Since the evaluator is responsible for distributing the correct set of forms, the evaluator will need to have a system to track clients who are approaching their semi-annual assessment or who are about to be discharged.

Tracking Data Collection
Data collection on each project will be overseen by the project evaluator. If there are problems with tardy data collection or forms completed incorrectly, it will be the project evaluator's responsibility to correct these problems. As part of this tracking of data collection, the project evaluator will make sure that a Consent to Participate (or decline) form is on file for every project participant.

Preparing Forms for Staff
The project evaluator will prepare the appropriate set of evaluation forms for the type of assessment. As discussed in Chapter 2, different assessment periods use different combinations of forms.

On the Face Sheet, the project evaluator will complete the client ID number, project code, distribution date, assessment type, and form linking number in the appropriate fields. These are described in Chapter 4.

For the CA-QOL and the MHSIP Consumer Survey, the evaluator will complete the client ID, distribution date, project code and form linking number. This is discussed in Chapters 5 and 6.

If not processing in-house but forwarding to DMH for processing, the project evaluator will also pre-address and stamp envelopes that are handed out with MHSIP Consumer Survey. This is discussed in Chapter 6.

Distributing Forms to Staff
Once the packet of forms is prepared with the identification fields completed, the project evaluator will distribute the forms to the appropriate staff.

Ensuring Qualified Staff Administer Forms
It is imperative that only staff trained in administering the forms are allowed to do so. If there is staff turnover, the project evaluator will need to train the new staff.

Maintaining File for Consent Forms
Consent (or decline) to participate forms will be maintained in a separate file from clinical records. This file will be maintained by the project evaluator in a locked cabinet. This file will be made available for inspection by State DMH when requested.

Cost Avoidance Analysis
As required in the legislation for the Supportive Housing Initiative Act (A.B. 2780, Statutes of 1998, Chapter 310), each funded project will be required to collect data to evaluate outcomes related to cost avoidance. This will be submitted to DMH within six months of the end of the project.

Project Specific Outcome Evaluation
Another requirement of the legislation is that the project must also complete an evaluation of project success in achieving each proposed outcome identified by grantees.

Being Important
The project evaluator is the key person in the evaluation efforts. If the data are bad, little can be said about the program's effectiveness and consumer reactions. Good data start with the project evaluator and well trained and committed staff. Filling out the forms is burdensome, but it is a small price to pay for the federal money. Good follow-up data provide support and rationale for additional funds. The critical person in all of this is the project evaluator. The state Department of Mental Health and the consumers thank you for your efforts.

GOOD LUCK!

Appendix A
Project Codes

SHIA PROJECTS BY FUNDING PERIOD

Funded in 1999-2000 (6)

Fresno County Mental Health	1011
Asian Pacific Counseling Center	1902
The Village (Long Beach)	1903
Marin Housing Authority	2101
San Diego County Mental Health	3701
The Arc of San Francisco	3801

Funded in 2000 - 2001 (5)

Redwood Community Actions	1201
Homes for Life	1904
Ocean Park Community Center	1905
Lamp Inc	1906
St. Vincent's De Paul - San Diego	3702

Funded in 2001 - 2002 (20)

Alameda County Housing and Community Development	0101
Building Opportunities for Self Sufficiency	0102
Fred Finch Youth Center	0103
Lifelong Medical Care	0104
Butte County Dept. of Behavioral Health	0401
Contra Costa County Health Services – Homeless Program	0701
A Community of Friends – Cornerstone Apt.	1907
Homes for Life Foundation	1908
Los Angeles County Dept. of Mental Health	1909
Project New Hope – Laguna Apts.	1910
Project New Hope – Nyumba, Hoover, Main St., Casa del Sol	1911
SRO Housing Corp.	1912
Interim, Inc.	2701
San Diego County Health and Human Services Agency	3703
The Assoc. for Community Housing Solutions	3704
San Francisco Dept. of Human Services	3802
San Joaquin County Dept. of Mental Health	3901
Santa Barbara County Dept. of Alcohol, Drug & Mental Health Services	4201
Emergency Housing Consortium	4301
Yolo Community Care Continuum	5701

Funded in 2001 - 2002 (15)

Coachella Valley Housing Coalition	n/a
Alameda County Housing and Community Development	0105
Oakland Community Housing, Inc.	0106
Fresno County Human Services System, Department of Adult Services	1012
A Community of Friends	1913
Hollywood Community Housing Corporation	1914
Mental Health Association in Los Angeles County	1915
Ocean Park Community Center	1916
Skid Row Housing Trust	1917
Marin Housing Authority	2102
Mendocino County Department of Mental Health	2301
Transitional Living and Community Support	3401
Alpha Project for the Homeless	3705
Chinatown Community Development Center	3803
City and County of San Francisco Department of Human Services	3804

California's Supportive Housing 2001 Evaluation
Protocols and Answers to Frequently Asked Questions

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Introduction

This document is intended to provide general information regarding Supportive Housing Evaluation as well as provide answers to the most frequently asked questions.

Individuals who have additional questions are encouraged to send them to the California Department of Mental Health for inclusion in this document. Additionally, those who submit questions are encouraged to suggest possible answers that should be considered in the establishment of policy relating to that issue. Questions, comments, and suggestion answers should be submitted, in writing to:

Supportive Housing 2001 Evaluation Protocols
Research and Performance Outcome Development
1600 9th Street
Sacramento, CA. 95814
Attention: Brenda Golladay

Additionally, questions, comments, and suggested answers may be emailed to:

bgollada@dmhhq.state.ca.us

Target Population Issues and Questions

- Who is the target population for the Supportive Housing Evaluation System?

  The target population for the demonstration projects are persons who have a serious mental illness and are homeless or at imminent risk of becoming homeless. Any client who is currently housed or who enters the demonstration project may be included in the evaluation.

Instrument Administration Schedule and Protocols

- How frequently are the supportive housing evaluation instruments to be administered?

  They are to be administered to all clients eligible to receive services that are funded by the grant monies. For existing clients who are eligible, the Face Sheet is to be administered initially for a baseline measure. As an existing client actually makes use of funded services, the instruments should be administered semi-annually, and at discharge. For new clients, they are to be administered upon intake, semi-annually thereafter, and at discharge.

- Exactly what do you mean by "Intake"?

  The term "intake" refers to the first 60 days during which the client receives services. This time period is essentially the same as the amount of time that could elapse before a coordinated care plan was to be developed. So when a client first begins receiving services the "clock" starts ticking.

- Are all of the supportive housing evaluation instruments administered each time?

  No. The Mental Health Statistics Improvement Program (MHSIP) Consumer Survey is not to be administered at intake. This is because it is assumed that clients have not had enough experience with the program to rate it reliably.

- Does the semi-annual administration of the instruments have to take place **exactly** 6 months after the intake set was administered?

  No. It is assumed that sometimes a client might come in for services slightly before or slightly after the 6th month. Therefore, a window has been identified during which it is assumed that the semi-annual set of instruments will be administered. This window is 2 weeks on either side of the semi-annual date.

- What if my program wants to administer the MHSIP at intake as well as semi-annually and at discharge?

  There is nothing that restricts you from using the MHSIP at intake. However, the State requirement is for administration only semi-annually and at discharge.

- Can the supportive housing evaluation instruments be administered more often than semi-annually?

  Yes. Some projects may find it useful to administer such instruments more frequently than semi-annually. However, any additional administration forms are <u>not</u> to be submitted to the State.

- Who administers the supportive housing instruments?

  With the exception of the Face Sheet which is completed by project staff, the other instruments (CA-QOL and the MHSIP Consumer Survey) are designed to be self-administered by the client. Clients can complete any one of these instruments in 20 minutes or less with little or no assistance, some clients will require extensive assistance. This could be due to reading skills or functioning levels. When assistance is required, it may be provided by virtually anyone who has been trained to administer the forms (e.g., peer counselors, clinicians, clerical staff, etc.) **with one exception—the MHSIP consumer survey**. The program staff must not administer this MHSIP consumer survey.

  Whenever assistance is provided to a client in order to complete the instruments, certain procedures should be followed. First, the person assisting should not interpret the items on the instruments. Second, the person assisting should not discuss the client's responses in any way that will affect those responses.

- What steps should be followed when administering instruments to non-English speaking clients?

  This is a very important question. Part of the answer applies to all efforts to help a client complete the forms. Assistance should be limited to simply reading the questions and marking the client's answers. No effort should be made to interpret the clients' responses. This would have the effect of introducing the clinician's (or other person's) bias into the results.

  The State DMH has worked with language experts to translate the CA-QOL and the MHSIP Consumer Survey forms into Spanish, Chinese, Vietnamese, Cambodian, Tagalog and Korean. These forms can be downloaded off the DMH web site at http://www.dmh.cahwnet.gov/RPOD/adult-net-caqol-mhsip.htm (see table towards the bottom of the page).

- What is the "Distribution Date" on the forms?

  The distribution date is being used to link sets of forms that were administered to a client at a given assessment. The specific date that is entered in the link date field is not nearly so important as the fact that **the distribution date should be the same on each instrument for a given administration**. Typically, the date that instruments are scheduled to be administered is the date that is used.

  Again, it is critical that the same distribution date be entered on each of the forms for a given administration.

  The key point is that each set of forms (i.e., admission set, discharge set, and semi-annual set) have the same dates. Thus, the set of admission forms will have a different date than the discharge set or the semi-annual set. Each client sets will have different dates.

- What is the best way to ensure that the distribution date is completed correctly?

  It is recommended that, before the instruments are provided to a staff for distribution to a client, the local project evaluator enter the critical information on each outcome instrument. This includes 1) Client Case Number (This is the same number that is reported to the DMH Client Services Information System), 2) Project Code, and 3) Distribution Date. Once this information is entered the instruments are distributed to the staff for use.

- Do the instruments all need to be completed on the same day?

  No. Of course, this would be ideal. However, it is not a problem if the instruments are completed over the course of several sessions as long as they are completed roughly around the same time period. This one of the reasons that our distribution dates is so important. Even though the instruments are administered on different days, we are able to identify which ones belong together as a set for a specific client.

- If a client completes a semi-annual set of instruments and then discharges shortly afterward, do I need to complete a discharge set?

  Yes. This set will have a different distribution date.

Confidentiality Procedures and Issues

- What kind of disclosure should be provided to the client regarding supportive housing information, what is collected, how it will be used, and who will have access to it?

General Information

Clients have the right to be informed of the goals of the study, to have the evaluation procedures explained, to be told about any possible benefits or risks expected from the evaluation, to be allowed to ask questions about the study, and to be allowed the choice to participate or not in the project evaluation. Clients will be informed of these rights when staff gives them a copy of the *Supportive Housing Evaluation Participant's Bill of Rights* and the *Consent to Participate* form. This will be the first form to be completed for each new client.

Administration Procedures

The Project Evaluator will give the *Consent to Participate* form and the *Supportive Housing Evaluation Participant's Bill of Rights* to staff along with the packet of the forms that are completed at admission. Within 60 days of admission, the client will be told about the evaluation and asked to participate in the Supportive Housing Project Evaluation.

Staff will give the client a copy of the *Supportive Housing Evaluation Participant's Bill of Rights*. The client may keep this copy. The staff will review each item with the client.

Next, staff will give the client the *Consent to Participate* form. Staff will review each of the items on the consent form. Staff will be explained to the client that she/he has the right to refuse to participate in the study. The client must be told that if he/she refuses to participate in the study, this will not affect his/her ability to receive services from the Supportive Housing Project.

Once it is clear that client understands the rights, the staff will ask the client if she/he wants to participate. If the client agrees to participate, the client will sign and date the form, and the staff will sign as a witness and date it as well.

Declines to Participate
If a client declines to participate, the staff will write across the bottom of the form, "Declines" and the client will be asked to sign next to the handwritten "Declines." Note that a client that is declining does not sign on the client's signature line; to sign on that line gives consent. Staff will sign and date the forms of clients who decline.

Maintaining Consent Forms
Since the Consent to Participate contains the client's name, the form will not be forwarded to DMH. The project evaluator will keep all the Consent to Participate forms in a single file. This file may be examined from time-to-time by the DMH State evaluator. When the file is examined, the project evaluator will obscure the names of clients, thus protecting client privacy.

Obtaining Forms
The State DMH will provide a clean copy of the *Supportive Housing Evaluation Participant's Bill of Rights* and the *Consent to Participate* form. The project evaluator will make clear copies to distribute to staff.

- If a client expresses concern about how confidential their responses are, what should I tell them?

  The information that they provide on the instruments is maintained in the client's file, which already has certain protections for confidentiality. The data that are reported to the state for supportive housing does not contain client names or addresses, but only demographic data and certain identifiers that will allow the outcome information to be linked to cost and service utilization data. At the project level, the supportive housing data are as secure other service data that are maintained for the client. When it is reported to the state DMH, the data are maintained in secure computer systems with very limited access. Nobody from outside the department could get access to the data without first going through proper channels. Even then, identifying information would be stripped out so that the client's confidentiality would be protected. Finally, if a client is worried s/he can decline to participate.

- How is the client's confidentiality protected?

    - Protecting client confidentiality is very important. Client confidentiality will be protected by the use of a client identification (ID) number. This ID will be protected by the county case number that is used to report data to the DMH Client Services Information (CSI) database. For clients without a CSI ID number, project evaluator and state evaluator will agree upon an alternative number. None of the evaluation forms will contain the client's name, address, or date of birth. Client ID number and date will link all forms. Moreover, the clients' Consent-To-Participate forms will be kept separate from the clinical files in a locked cabinet.

- What if a client refuses to complete the supportive housing evaluation instruments?

    It is not a requirement that a client complete the outcome instruments in order to receive services. It is their right to refuse to complete the instruments. Should a client refuse to complete the instruments, the refusal must be documented in the file. It is recommended that staff simply write across the front page of each instrument that was refused the words "CLIENT REFUSED."

- The MHSIP Consumer Survey collects pretty specific information regarding how the client feels about the services he or she is receiving. What should they be told about the confidentiality of their responses and how their responses will be used?

    The MHSIP Consumer Survey is unique among the supportive housing instruments. While the staff will have access to the other instruments that the client completes CA-QOL (Quality of Life Survey), this is not the case with the MHSIP Consumer Survey. The MHSIP data will be reported only on an aggregate level.

    This will allow staff to see how their clients have perceived the care they received but they will be unable to identify any individual client. Thus, a client's responses will be kept confidential.

    Please refer to the sections on "Confidentiality" and "Administration Procedures" in Chapter 6 beginning on page 42 for additional information.

APPENDIX C - PSYCHOMETRICS

General Information

The term "psychometrics" refers to the practice and technology of applying statistically-based techniques toward the measurement and understanding of psychological "events". These events could include attitudes, personality traits, aptitudes and abilities, and underlying factors relating to psychological functioning. In a clinical setting, which by design is generally centered on a specific individual, some feel that using statistically based assessment tools is not appropriate. Rather, these individuals feel that it is the clinician's professional judgment which grows out of the establishment of a relationship of mutual trust that is most important.

No reasonable psychometrician would claim that statistical data is more important than the relationship that exists between service provider and client. However, psychometric data can, if used appropriately, provide a very valuable piece of the puzzle that helps the clinician to develop a more complete picture of the client. Specifically, **psychometric data provides three essential components to the diagnosis, treatment planning, and service provision process**:

1) Well Defined Areas of Measurement

Scores that are derived from appropriately designed psychometric-based assessment instruments are generally well defined so that something meaningful can be said about a person based on his or her score on that instrument.

2) Reliability

There is evidence that the diagnostic process, when based on clinician judgment alone, is not particularly reliable. In other words, if several clinicians evaluate the same client using the same information, their diagnoses will likely differ to some degree. To the extent that specific diagnoses are more amenable to specific treatment modalities, arriving at an appropriate diagnosis is critical to providing the best service to clients. With psychometric-based data, it is possible to state, in a quantifiable way, how much confidence may be placed in scores that describe the client. This is not to say that those scores are necessarily a complete picture of the client, however. But when psychometric data are used in conjunction with a clinicians clinical judgment, greater confidence may be placed in the overall treatment planning process.

3) Validity

The third and final essential component that psychometric data brings to the diagnosis, treatment planning, and service provision process is a quantifiable level of validity. Because of the intimate and person-centered nature of the clinician-client relationship, a wide variety of factors enter into the judgments made by the clinician about the client. For example, the nature of the clinician's training will guide diagnostic procedures, and will likely lead to a focus on client behaviors that were emphasized in his or her training; the clinician's own recent and overall professional experience will affect how he or she approaches the client; because the clinician is human, it is likely that his or her own emotional state and personal beliefs will affect judgments made about the client; finally, the administrative environment in which the clinician works will likely place constraints on how the clinician-client relationship develops.

Because of the way that psychometric-based assessment instruments are developed, it is possible--within limits--to be sure that the instrument is mainly measuring what it is supposed to measure. This is referred to as "instrument validity." Stated in other terms, validity refers to the extent to which an instrument is measuring what it is supposed to measure and that the clinician can make appropriate judgments based on the instrument score(s).

Some Basic Concepts in Psychometrics

Reliability

Broadly defined, reliability simply refers to the confidence that you can have in a person's score. In some cases, you want to be able to have confidence that the individual would have the same score over time. This is because you have reason to believe that what is being measured should not change over time. For example, if a person passes a driving test in January it is hoped that the same individual would pass the test one year later. At other times, it may not be appropriate to expect that scores would remain consistent over time. For example, it is hoped that if a client receives treatment for depression, the score that the client would receive on a measure of depression should decrease over time. Psychometricians and other measurement specialists have developed various methods of establishing reliability to meet these varying needs. Some of these are listed below:

Test-Retest Reliability

In test-retest reliability methodologies, an assessment instrument is administered at time 1 and then again at some later date(s). To the extent that the scores that the client receives are the same on both administrations, the two sets of scores will be positively correlated. The correlation coefficient between these two administrations then becomes an estimate of the ability of the assessment instrument to reliably assess the client over time.

Problems with this approach: The main problem with the test-retest approach to establishing validity is that a wide variety of intervening variables can come into play between the first and subsequent administrations of the instrument. An example from the educational setting might be that a college entrance examination is administered to students at the beginning of their Junior year of high school. If the same instrument were administered again at the end of those same students' senior year, the scores would likely be quite different due to all of the intervening learning that took place. From a psychological standpoint, if a person completed a measure of depression at time one and them experienced some major life event before the second administration of the measure, the estimate of the instrument's reliability would appear low. Finally, it is possible that, having completed the instrument one time the clinician's or client's responses may be affected at the second administration if he or she remembers the previous responses.

If, on the other hand, it is hypothesized that whatever the assessment instrument is measuring really should not change over time, then the test-retest approach is a powerful method of establishing this fact.

Parallel Forms Reliability

Another way of establishing reliability is to develop two forms of the same instrument. In theory, if the two forms are measuring the same thing (e.g., depression), then the scores on the two forms should be highly and significantly correlated. To the extent that they are in fact correlated, the correlation coefficient is roughly a measure of parallel forms reliability.

Problems with this approach: There are several problems with this method of establishing reliability. First, it can be expensive to develop two parallel forms. The second and perhaps greater problem is that there is always a certain amount of "criterion contamination" or

variance that is unrelated to what is intended to be measured in an instrument score. This is compounded in that if there is a certain amount of unsystematic variance in each assessment instrument, then the sum of that variance across the two forms will reduce the reliability between the forms.

Split-Half Reliability

This method of establishing reliability is similar to the parallel forms method--but with one important difference. To use the split-half method, an assessment instrument is administered to a group of individuals. Next the instrument is essentially randomly divided into to equal portions. These two portions are then evaluated to examine how strongly they are correlated. Assuming that the instrument is measuring a common trait, ability, or psychological dimension, each half of the randomly divided instrument should be a measure of the same thing. Therefore, scores on each half should be highly correlated.

Problems with this approach: There are two main problems with this approach. First, when you divide the assessment instrument in half, you effectively reduce the number of items from which the total score is calculated by half. Thus, you may by nature have a score on each half that is of lower reliability and therefore any correlation between the two halves could be reduced. Therefore, the overall estimate of reliability could appear inappropriately low. The second problem is that even though the assessment instrument was randomly divided, there is no guarantee that the two halves are actually equivalent. To the extent that they are not, the estimate of overall reliability will be lower.

Internal Consistency

The internal consistency approach to establishing reliability essentially evaluates the inter-item correlations within the instrument. Ultimately, an estimate of reliability is generated that is equivalent to the average of all possible split-half divisions that could have been made for that instrument.

TABLE 3-1: Summary of Reliability Methodologies

Method	Strengths	Weaknesses
Test-Retest Reliability	• Correlates scores from two separate administrations of an instrument. • Correlation coefficient estimates instrument's ability to reliably assess client over time.	• A wide variety of intervening variables between the first and subsequent administrations of the instrument could alter the results.
Parallel Forms Reliability	• Correlates scores of two forms of an instrument designed to measure the same thing. • Correlation coefficient estimates instrument's ability to measure the target domain.	• It can be expensive to develop two parallel forms. • There is always a certain amount of variance unrelated to what is intended to be measured in an instrument score that would reduce the reliability between the forms.
Split-Half Reliability	• Correlates scores for two equal, randomly divided portions of an instrument. • Correlation coefficient estimates instrument's ability to measure the target domain.	• Since only 50% of the items are used per score, the overall estimate of reliability could appear inappropriately low. • To the extent that the two halves are not equivalent, the estimate of overall reliability will be lower.
Internal Consistency	• Evaluates the inter-item correlations within the instrument. • An estimate of reliability is generated equivalent to the average of all possible split-half divisions.	

Validity

Some people misuse the term "validity" when they refer to assessment instruments. It is inappropriate to say that an assessment instrument is valid. Rather, it is the inferences or decisions that are made on the basis of an instrument's scores that are either valid or invalid. In order to be

able to make valid inferences about a client based on his or her score on an instrument, the instrument must be measuring what it was intended to measure. This point cannot be emphasized enough.

When a client completes an instrument that is designed to evaluate his or her psychological functioning, if the instrument uses terms that, while common in a European cultural setting, may not be familiar in an Asian setting, then the inferences based on the instrument scores may not be appropriate for Asians. Threats to validity do not have to be nearly so extreme or obvious to make interpretation of scores invalid for making assessments. Therefore, it is important for users of test information to understand methods of test validation, the strengths and weaknesses of each, and what types of inferences are more appropriate for the method of validation that was used. Several validation methods are discussed briefly below.

Content Validity

When one says that an instrument is content valid, it indicates that the individual items that make up the instrument are reflective of the specific domain that they are intended to measure. For example, in an instrument designed to measure quality of life, if that instrument contains items such as indicators of living situation, independence, self-sufficiency, etc. (assuming these have been documented by a group of individuals as measuring quality of life), then the instrument may arguably be called "content valid."

Criterion-Related Validity

There are basically two methods of employing criterion-related validation strategies. These are: a) predictive and b) concurrent.

In predictive criterion-related validation strategies, the goal is to develop an instrument that is able to predict a persons later score, performance, or outcome based on some initial score. Examples of such predictive instruments include the General Aptitude Test Battery (GATB), Armed Services Vocational Aptitude Battery (ASVAB), Scholastic Aptitude Test (SAT), and Graduate Record Examination (GRE).

In concurrent criterion-related validation strategies, the goal is to effectively discriminate between individuals of groups on some current trait. For example, the Minnesota Multiphasic Personality Inventory (MMPI) was developed using a method called criterion

keying to develop an instrument that was extremely powerful at identifying whether or not a person was currently experiencing psychoses.

The criterion-related validation approach can be extremely powerful. However, it suffers from a variety of conceptual and/or logistical problems. Although I will not delve deeply into the statistical reasons for these problems, I will list them. Using a criterion-related validation strategy:

- It is difficult to develop parallel forms.
- Instruments tend to have low internal consistency.
- To maximize predictive power, items should have minimal correlations with each other but maximum correlations with the external criterion. This makes it methodologically difficult to identify test items.
- Instruments tend to have low face validity.

Construct Validity

Construct validation approaches utilize factor analysis to identify items that appear to be highly correlated to one another. To the extent that items are, in fact, correlated to each other they are assumed to be measuring something in common. Exactly what those items are measuring is difficult to say. What test developers do is review the content of the items and try to identify commonalties in the subject matter that they cover. For example, if a group of inter-correlated items addresses such things as sleeplessness, lack of energy, frequent crying, fear of being alone, etc., a test developer may decide that these items are measuring the construct of depression.

What is a construct? It is important to keep in mind that a construct does not exist. Rather, it is a theoretical creation to explain something that is observed. Returning to our example of a depression construct, depression is not a thing that exists. Rather, it is simply a name that we have given to a group of traits or a level of psychological functioning.

Face Validity

Face validity simply refers to the extent to which an assessment instrument "appears" to be related to what it purports to measure. For example, a driving test is face valid because all of the questions that are asked are related to laws and situations that a driver may be faced with. Therefore, even if we don't like driving tests, most of use feel that they are at least somewhat related to driving.

On the other hand, someone may find that math ability is related to driving ability. If this occurred, it would be possible to administer a math test and, based on the scores a test taker received, either approve or deny a drivers license. In this case, a math test could be valid for use in predicting driving behavior, but it would not be face valid because it would "appear" unrelated to the task of driving.

Face validity is important in most assessment settings because people inherently like to make sense out of what they are doing. When clinicians, clients, family members, or anyone else are asked to fill out an assessment instrument, they will feel better about doing so and will likely provide more accurate data if they feel that the information they provide makes sense and can see how it can be useful.

TABLE 3-2: Summary of Validation Methodologies

Method	Strengths	Weaknesses
Content Validity	• Provides an indication of how the individual items that make up the instrument are reflective of the specific domain that they are intended to measure.	• Assumes that the area being measured is clearly understood. • To the extent that what is being measured is conceptual or multi-dimensional, effective content-oriented items may be difficult to develop.
Criterion-Related Validity	• *Predictive strategies* provide an indication of how well the instrument is able to predict a later score, performance, or outcome based on some initial score. • *Concurrent strategies* provide an indication of how the instrument effectively discriminates between individuals or groups on some current trait.	• It is difficult to develop parallel forms using this approach. • Instruments tend to have low internal consistency. • To maximize predictive power, items should have minimal correlations with each other but maximum correlations with the external criterion making it methodologically difficult to identify test items. • Instruments tend to have low face validity.
Construct Validity	• Utilizes factor analysis to identify items that appear to be highly correlated to one another in order to develop assessment instruments that measure a common construct.	• Exactly what a group of inter-correlated items is measuring may be difficult to ascertain.
Face Validity	• Provides an indication of how the assessment instrument "appears" to be related to what it purports to measure	• Not really an indicator of validity. Rather, it is based on the assumption that data will be more valid when respondents see the relationship between the instrument and what it is supposed to measure.

Conclusion

Psychometric data is intended to provide an additional tool for clinicians and other service providers to use as they plan and conduct their treatment. It is not intended to supplant or replace clinical judgment. The above issues have been discussed to help those who use data generated from the Children and Youth Performance Outcome System evaluate and make more effective and appropriate use of their client's assessment data.

It is important to understand which method was used to validate each of the clinical assessment instruments so that you can know what kinds of judgments may be made about the scores. Knowing that an instrument is reliable and how the reliability was established can help the clinician have confidence in the scores as well as know what kinds of changes are reasonable to expect.

Finally, the remainder of this training document goes into additional detail on each of the assessment instruments. Each instrument's validity, reliability, administration and scoring procedures, interpretation, and use will be discussed. The above information is intended to help you make sense of this.

Sources of Further Information

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